NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

MH/DD/SAS Community Systems Progress Report

First Quarter SFY 2008-2009

July 1 – September 30, 2008

Prepared by:
Quality Management Team
Community Policy Management Section
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

December 15, 2008

Quality
NC DMH/DD/SAS

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.

-- William A. Foster. Quotations. Quotations Book, 2005.

Highlights of First Quarter SFY 2008-2009

Timely Access to Care

- According to data reported to the Division from the Local Management Entities (LMEs), almost all of the individuals (99%) determined to need emergent care were provided a face-to-face service (assessment and/or treatment) within two hours from the time of the request. Another one percent had a provider on-site within two hours ready to give care when the individual was available.
- LMEs reported that 77% of individuals determined to need urgent care were provided a face-to-face service within 48 hours from the time of the request (failing to meet the SFY 2009 target of 88%).
- Two-thirds (66%) of individuals determined to need routine care were provided a face-to-face service within 14 calendar days from the time of the request (failing to meet the SFY 2009 target of 88%).

Services to Persons in Need

- In the first quarter of the fiscal year, mental health consumers receiving federal or state funded services in their communities **met the SFY 2009 target for adults** (40% served compared to the target of 40%) and have **exceeded the target set for children** with 47% served compared to the target of 40%.
- Developmental disability consumers receiving federal or state funded services in their communities are within 1% of meeting the SFY 2009 target for adults (37% served compared to the target of 38%) and have **met the target set for children** (20% served compared to the target of 20%).
- In the first quarter of the fiscal year, services to adult and child substance abuse consumers met the SFY 2008 target (8% and 7% served, respectively), and are on their way towards achieving the higher SFY2009 targets of (10% and 9% served, respectively).

Timely Initiation and Engagement in Service

- Statewide, the SFY 2009 **target for initiation of mental health consumers into care was met this quarter** with 42% of consumers receiving a 2nd visit within 14 days of the first visit compared to the target of 42%. In contrast, the SFY 2009 target for engagement of these consumers was not met this quarter with only 28% of consumers receiving 2 additional visits within 30 days after meeting the initiation measure, compared to the target of 30%.
- Statewide, 68% of consumers with developmental disabilities received 2 visits within the first 14 days of care (four percentage points below the SFY 2009 initiation target of 72%). Similarly, 53% of developmental disability consumers had 4 visits within 45 days of beginning care compared to the SFY 2009 target for engagement of 61%. This represents an eight percent increase over the prior quarter's 63% for initiation and a ten percent increase over the prior quarter's 48% for engagement.
- The SFY 2009 target for initiation of substance abuse consumers into care was not met this quarter. Sixty-two percent of these consumers received 2 visits within the first 14 days of care (compared to the target of 71%). Less than half of substance abuse

consumers (46%) received 4 visits within 45 days of care, failing to meet the SFY 2009 target of 56%.

Effective Use of State Psychiatric Hospitals

- Consumers receiving short term care (7 days or less) in state psychiatric hospitals did not meet the SFY 2009 target this quarter. 51% of consumers had stays of 7 days or less compared to the SFY 2009 target of 44% or fewer consumers admitted to state psychiatric hospitals with stays of 7 days or less. This was the same percentage as last quarter.

State Psychiatric Hospital Readmissions

- Across the state, 10% of consumers discharged from a state psychiatric hospital were readmitted within 1 to 30 days. This is 1% **better than the SFY 2009 target** of 11% or less. Within 1 to 180 days, 23% of consumers were readmitted, **meeting the SFY2009 target** of 23% or less.

Timely Follow-Up after Inpatient Care

- The SFY 2009 targets for follow-up care for consumers discharged from ADATCs and state psychiatric hospitals were significantly increased to 70% of consumers seen within 1 to 7 days following discharge. This increase reflects the great importance and high priority given to the achievement of this measure this year. Statewide, 25% of consumers discharged from ADATCs and 36% of consumers discharged from state psychiatric hospitals were seen within 1 to 7 days following discharge this quarter. These numbers represent a nine percent increase over last quarter's 23% seen within 7 days of discharge from an ADATC and a three percent increase over last quarter's 35% seen within 7 days of discharge from a state psychiatric hospital.

Child Services in Non-Family Settings

- Like the last report, only four percent of children and adolescents receiving mental health and/or substance abuse services were served in non-family settings (Level 2 Program, Level 3, or Level 4 residential treatment) this quarter, which is **better than the SFY09 target** of five percent or less.

Table of Contents

Introduction

This report marks the beginning of the third year in which the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) has been tracking the effectiveness of community systems through statewide performance indicators.[1] These indicators provide a means for the public and General Assembly to hold DMH/DD/SAS, the Local Management Entities (LMEs), and provider agencies accountable for progress toward the goals of the Mental Health System Reform. Regular reporting of community progress also assists local and state managers in identifying areas of success and areas in need of attention. Problems caught early can be addressed more effectively. Success in a particular component of the service system by one community can be used as a model to guide development in other communities.

Each topic covered by these indicators involves substantial "behind-the-scenes" activity by service providers, LME and state staff, consumers, and family members. These indicators do not purport to cover all of those efforts. Instead, they address the desired results of those activities as a way to guide decisions about more detailed analysis by system stakeholders into issues that affect progress toward the goals of MH/DD/SAS system transformation. The indicators were chosen to reflect:

- accepted standards of care,
- fair and reliable measures, and
- readily available data sources.

The following pages present graphs showing the progress of each LME on the selected indicators for the most recent time period available.[2] The source information below each graph provides details on the data systems and time periods used.

Each indicator includes a statewide target to be achieved by the end of the fiscal year. These targets are indicated by a red line across the graphs on the following pages. The Division has set higher targets for areas of greatest concern, notably seeking the greatest improvements in substance abuse services and in decreased use of state psychiatric hospitals.

Appendices for MH/DD/SAS Community Systems Progress Report, a separate document, contain the formulas for calculating the indicators and tables showing the statistics for each LME on all indicators. *Critical Measures at a Glance*, a new one-page summary of the report, as well as the full report and appendices, are available on the Division website at:

http://www.ncdhhs.gov/mhddsas/statspublications/reports

The indicators and targets in this report mirror requirements of the SFY 2008-2009 *DHHS-LME Performance Contract*. Performance standards required by the Contract are noted at the bottom of each graph. However, the emphasis of the *Community Systems Progress Reports* remains on highlighting gains made toward desired results rather than compliance with basic requirements. For this reason, a text box below each graph highlights the number of LMEs that achieved the fiscal year target during the reporting period.

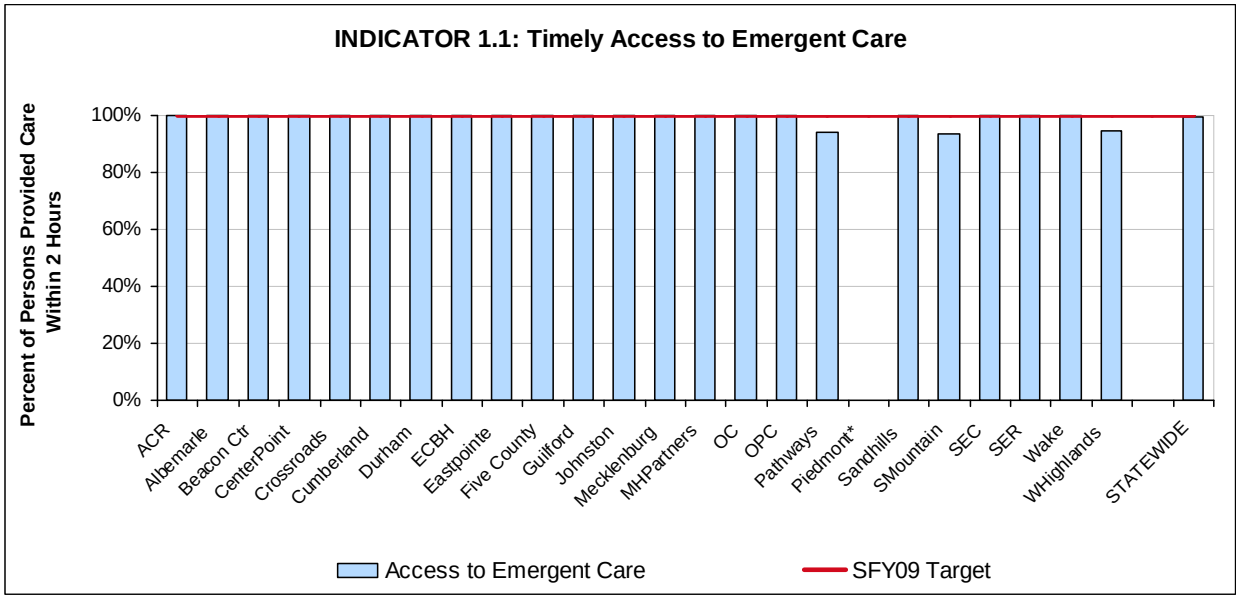
[1] This report fulfills the requirements of S.L. 2006-142 (HB 2077) that directs the Department of Health and Human Services to develop critical indicators of LME performance. Measures reflect the goals of the NC State Plans 2007-2010, the President's New Freedom Initiative, CMS' Quality Framework for Home and Community Based Services, and SAMHSA's Federal Action Agenda and National Outcome Measures.

[2] Measures relying on service claims data are delayed by 90 to 180 days to allow time for claims to be processed. Data on service claims for Piedmont LME, which is operating under a Medicaid waiver, were not available.

Indicator 1: Timely Access to Care

1.1 Emergent Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. July 1 - September 30, 2008; N=8,276 persons in need

Statewide, according to LME self-report data, 100% of persons determined to need emergent care had a provider on-site within two hours of the time of the request, ready to give care once the individual was available. Of those, 99% were provided federal or state funded services through our community service system within that time frame (see Appendix for details).

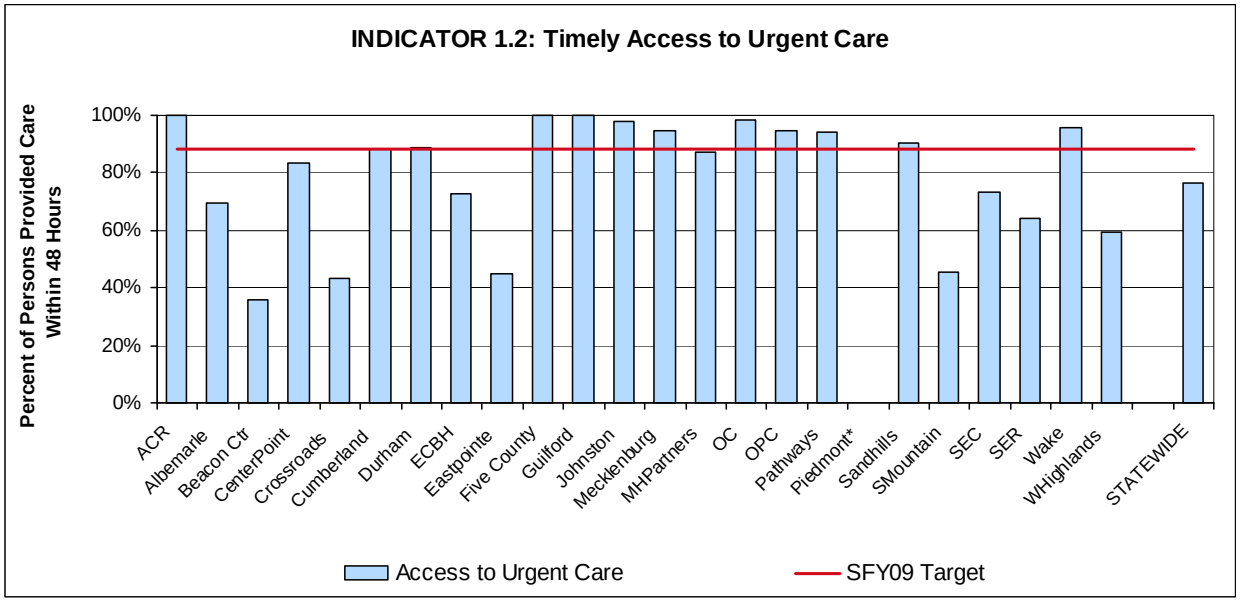
The established SFY 2009 target for access to emergent care is 100%, as indicated by the red line in the graph above[3]. Of the 23 LMEs reporting, 20 met the target.

[3] The SFY 2009 DHHS-LME Performance Contract requirement is 100%.

Indicator 1: Timely Access to Care

1.2 Urgent Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. July 1 - September 30, 2008; N=6,116 persons in need

Statewide, according to LME self-report data, 77% of persons determined to need urgent care were provided federal or state funded services through our community service system within 48 hours from the time of the request. The rate of persons who were served within the 48-hour period varied among LMEs from a low of 36% (Beacon Center) to a high of 100% (Alamance-Caswell-Rockingham, Five County, and Guilford).

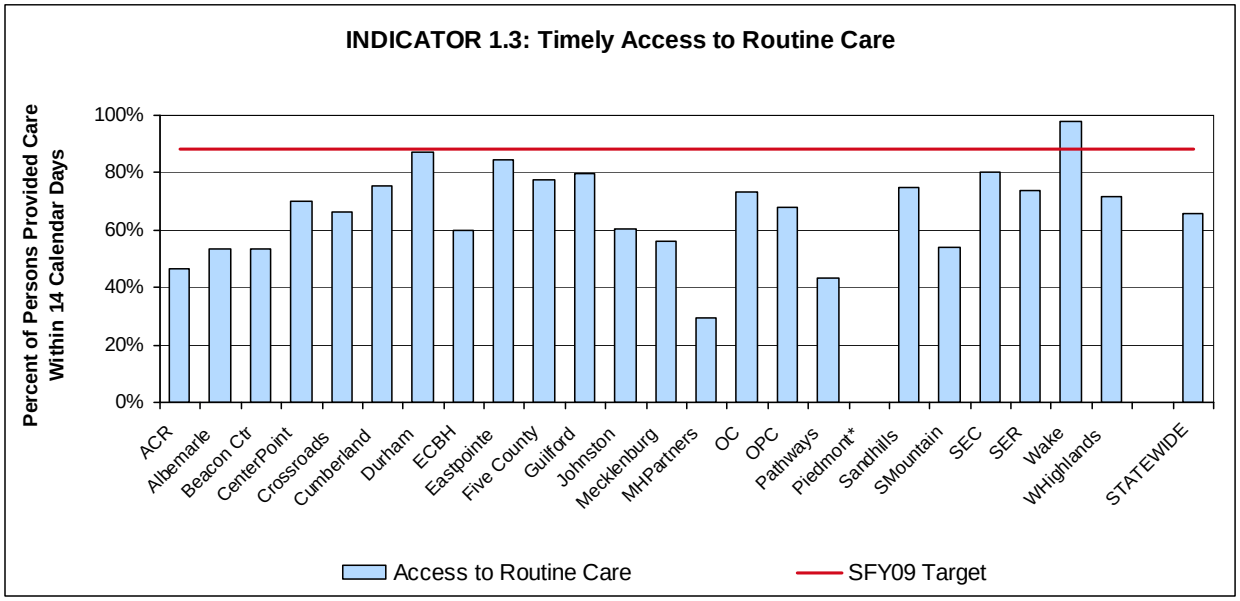
The established SFY 2009 target for access to urgent care is 88%, as indicated by the red line in the graph above[4]. Of the 23 LMEs reporting, 12 LMEs met or exceeded the target.

[4] The SFY 2009 DHHS-LME Performance Contract requirement is 80% or above.

Indicator 1: Timely Access to Care

1.3 Routine Care

Rationale: Timely access to appropriate care is critical to protect consumer health and safety, minimize adverse consumer outcomes and promote consumer engagement in services. The timely access measures are based on Healthcare Enterprise Data Information System (HEDIS ©) measures, supported by the federal Centers for Medicaid and Medicare.



SOURCE: LME data reported to DMH/DD/SAS. July 1 - September 30, 2008; N=26,510 persons in need

Approximately two-thirds (66%) of persons determined to need urgent care were provided federal or state funded services through our community service system within 14 calendar days from the time of the request. The rate of persons who were served within the 14-day period varied among LMEs from a low of 29% (Mental Health Partners) to a high of 98% (Wake).

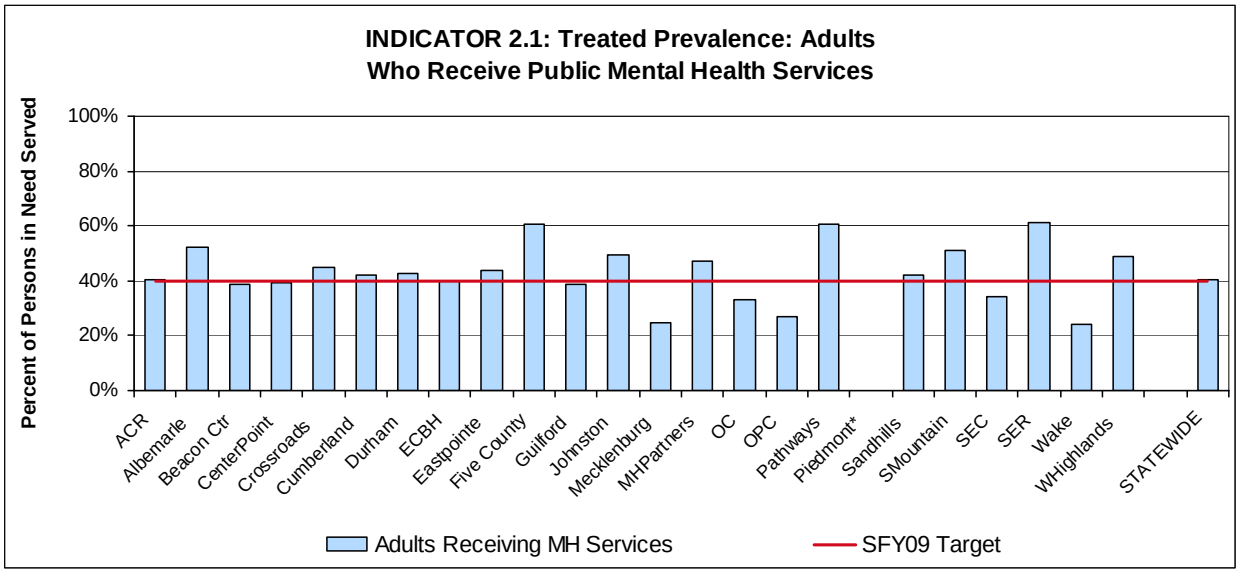
The established SFY 2009 target for access to routine care is 88%, as indicated by the red line in the graph above[5]. Of the 23 LMEs reporting, only one LME met or exceeded the target.

[5] The SFY 2009 DHHS-LME Performance Contract requirement is 80% or above.

Indicator 2: Services to Persons in Need

2.1 Adult Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=349,824 adults in need

Statewide, 141,634 adults (40% of those in need of services[6]) received federal or state funded MH services through our community service system from July 2007 through June 2008.[7] The rate of adults who were served varied among LMEs from a low of 24% (Wake) to a high of 61% (Five County, Pathways, Southeastern Regional).

The established SFY 2009 target for persons receiving adult mental health services is 40% or higher, as indicated by the red line in the graph above[8]. Of the 23 LMEs with service claims data, almost two-thirds of the LMEs (15 LMEs) met or exceeded the target.

[6] URS Table 1: Number of Persons with Serious Mental Illness [*sic*], age 18 and older, by State, 2007, Civilian Population with SMI (5.4%). Prepared by NRI/SDICC for CMHS: June 14, 2008. Estimates applied to county population as of July 2008.

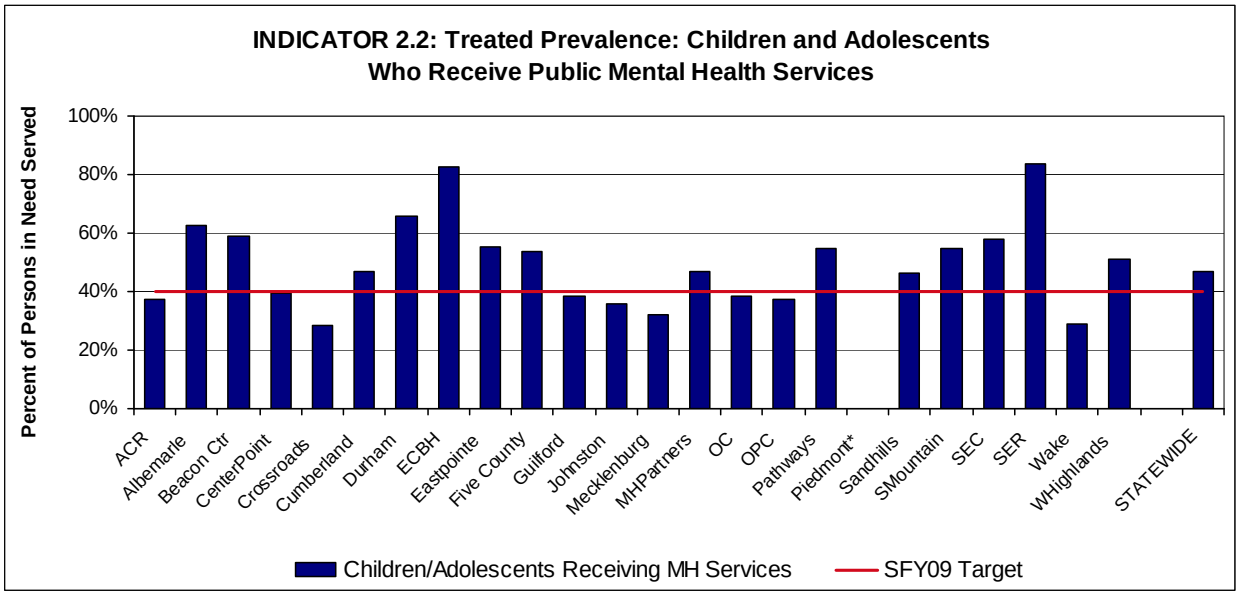
[7] The numbers served reflect adults, ages 18 and over, who received any MH services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, Tri-Care, county funds, other federal, state, and local agencies, and private funds. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[8] The SFY 2009 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.2 Child and Adolescent Mental Health Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=204,432 children and adolescents in need

Statewide, 95,696 children and adolescents (47% of those in need of services[9]) received federal or state funded MH services through our community service system from July 2007 through June 2008.[10] The rate of those served varied from a low of 28% (Crossroads) to a high of 84% (Southeastern Regional).

The established SFY 2009 target for persons receiving child mental health services is 40%, as indicated by the red line in the graph above[11]. Of the 23 LMEs with service claims data, almost two-thirds (15 LMEs) met or exceeded the target.

[9] URS Table 1: Number of Children with Serious Emotional Disturbances [*sic*], age 9 to 17, by State, 2007, Level of functioning score=60, midpoint of range between lower and upper limits of estimates. Prepared by NRI/SDICC for CMHS: June 14, 2008. The Division applies the estimates established by CMHS for children ages 9-17 to those under the age of 9, since no established estimates exist for younger children. Estimates applied to county population as of July 2008.

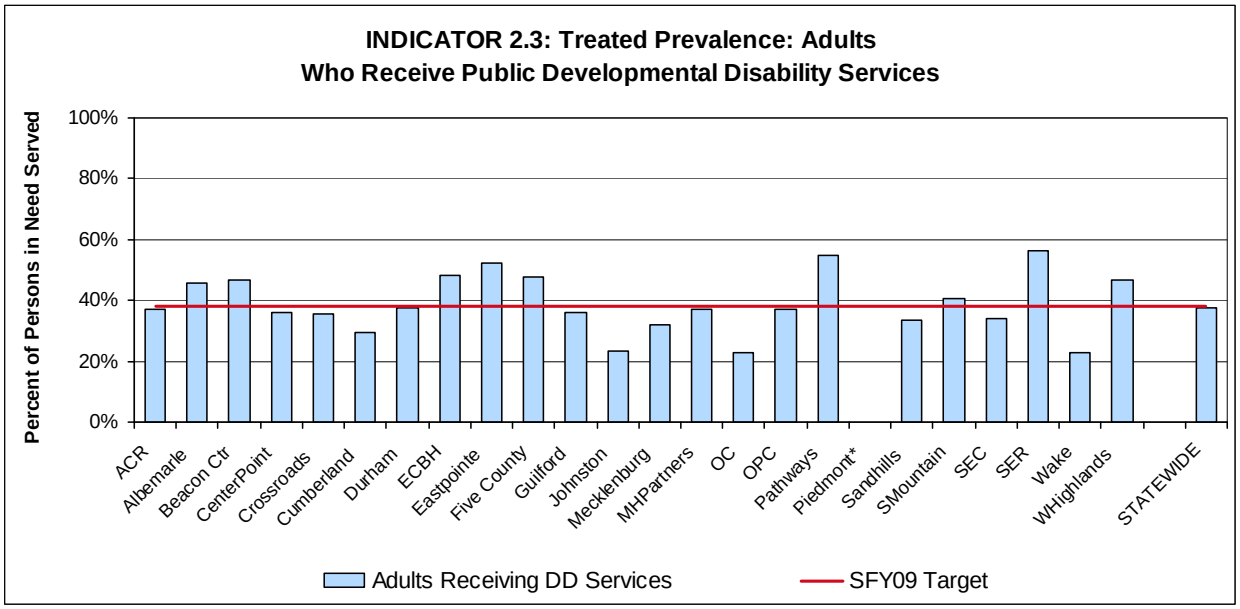
[10] The numbers served reflect children and adolescents, ages 3-17, who received any MH services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private funds. The NC Division of Public Health is responsible for all services from birth through age 2. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[11] The SFY 2009 DHHS-LME Performance Contract requirement is 38% or above.

Indicator 2: Services to Persons in Need

2.3 Adult Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=51,065 adults in need

Statewide, 19,119 adults (37% of those in need of services[12]) received federal or state funded DD services through our community service system from July 2007 through June 2008.[13] The rate of adults who were served varied among LMEs from a low of 23% (Johnston, Onslow-Carteret, and Wake) to a high of 56% (Southeastern Regional).

The established SFY 2009 target for persons receiving adult developmental disability services is 38%, as indicated by the red line in the graph above[14]. Of the 23 LMEs with service claims data, two-fifths (10 LMEs) met or exceeded the target.

[12] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Prevalence rates for persons ages 3-5 = 3.8%, ages 6-16 = 3.2%, ages 17-24 = 1.5%, ages 25-34 = 0.9%, ages 35-44 = 0.8%, ages 45-54 = 0.7%, ages 55-64 = 0.5%, ages 65and older = 0.4%. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

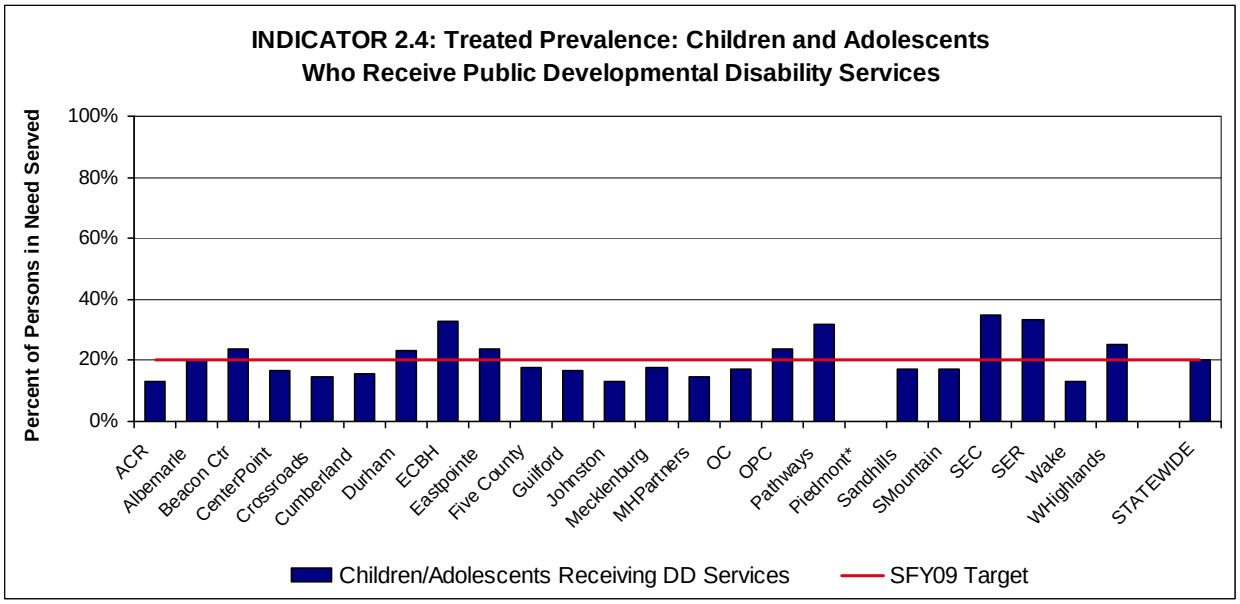
[13] The numbers served reflect adults, ages 18 and over, who received any DD services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[14] The SFY 2009 DHHS-LME Performance Contract requirement is 36% or above.

Indicator 2: Services to Persons in Need

2.4 Child and Adolescent Developmental Disability Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=54,613 adolescents in need

Statewide, 10,954 children and adolescents (20% of those in need of services[15]) received federal or state funded DD services through our community service system from July 2007 through June 2008.[16] [17] The rate of those who were served varied among LMEs from a low of 13% (ACR, Johnston, and Wake) to a high of 35% (Southeastern Center).

The established SFY 2009 target for persons receiving child developmental disability services is 20%, as indicated by the red line in the graph above[18]. Of the 23 LMEs with service claims data, approximately two-fifths of the LMEs (10 LMEs) met or exceeded the target.

[15] Fact Sheet 2: Estimated Ages of People with MR/DD in US Non-Institutional Population from the 1994 and 1995 National Health Interview Survey (NHIS), http://rtc.umn.edu/docs/fs0102.html. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

[16] The numbers reflect children and adolescents, ages 3-17, who received any DD services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

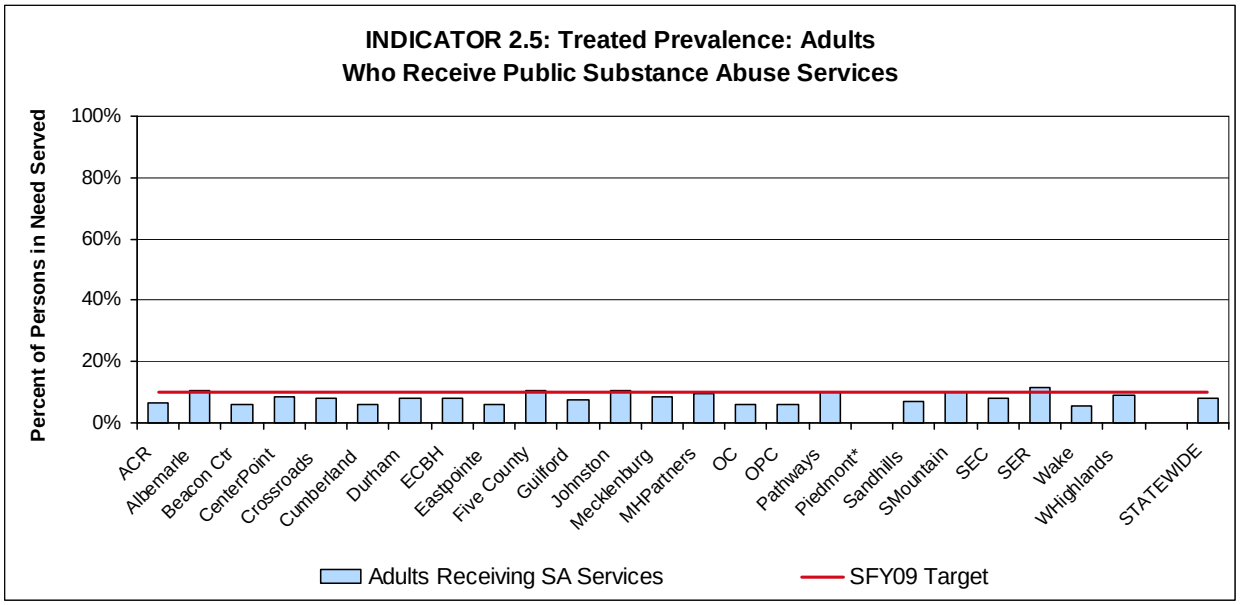
[17] The NC Division of Public Health is responsible for all services from birth through age 2. Local educational systems are responsible for educational services to children with developmental disabilities through age 21.

[18] The SFY 2009 DHHS-LME Performance Contract requirement is 19% or above.

Indicator 2: Services to Persons in Need

2.5 Adult Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=564,796 adults in need

Statewide, 45,224 adults (8% of those in need of services[19]) received federal or state funded SA services through our community service system from July 2007 through June 2008.[20] The rate of adults who were served varied among LMEs from a low of 5% (Wake) to a high of 11% (Johnston and Southeastern Regional).

The established SFY 2009 target for persons receiving adult substance abuse services is 10%, as indicated by the red line in the graph above[21]. Of the 23 LMEs with service claims data, one-quarter or six LMEs (Albemarle, Five County, Johnston, Pathways, Southeastern Center, and Smoky Mountain) met or exceeded the target.

[19] *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*, Table B.20, published February 2008, http://oas.samhsa.gov/nsduh.htm. Age appropriate estimates applied to county population as of July 2008 (See *Appendix*).

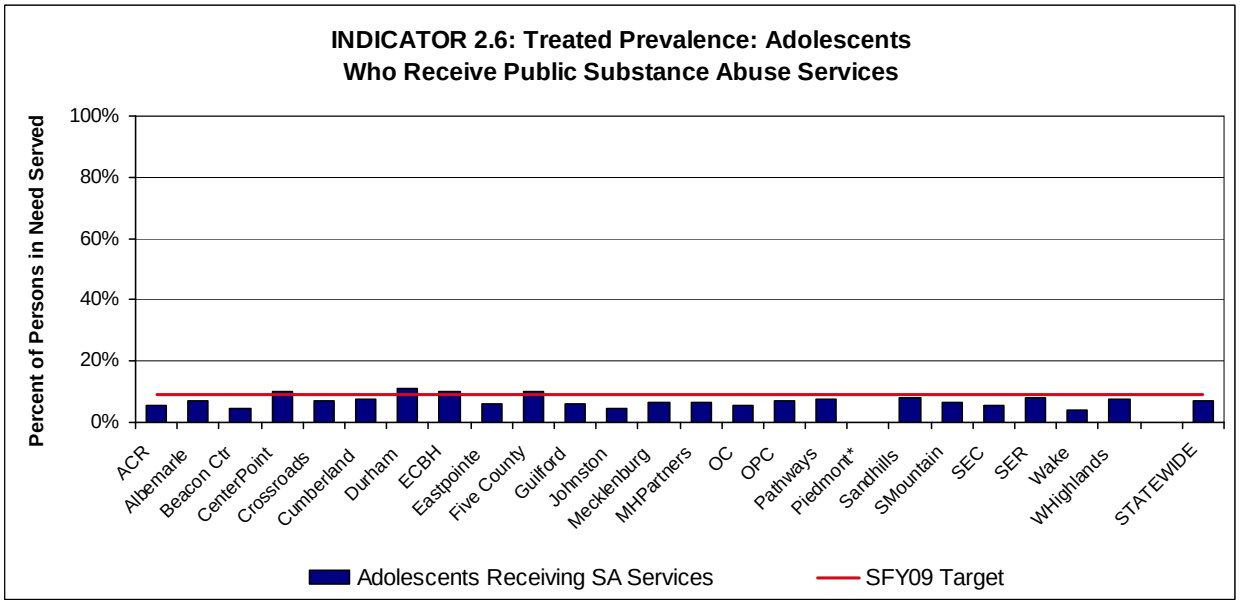
[20] The numbers served reflect adults, ages 18 and over, who received any SA services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services, some geriatric services, and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[21] The SFY 2009 DHHS-LME Performance Contract requirement is 8% or above.

Indicator 2: Services to Persons in Need

2.6 Adolescent Substance Abuse Services

Rationale: NC has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This indicator is measured by comparing the number of persons who received ***treatment*** for a particular condition with ***prevalence***, the number of persons estimated to have that condition in a given year, to get ***treated prevalence***, or percent of the population in need who receive services for that condition within a year.



SOURCE: Medicaid and State Service Claims Data. July 1, 2007 - June 30, 2008; N=53,144 adolescents in need

Statewide, 3,689 adolescents (7% of those in need of services[22]) received federal or state funded services through our community service system from July 2007 through June 2008.[23] The rate of targeted adolescents who were served varied among LMEs from a low of 4% (Beacon Center and Wake) to a high of 11% (Durham).

The established SFY 2009 target for persons receiving child substance abuse services is 9%, as indicated by the red line in the graph above[24]. Of the 23 LMEs with service claims data, four LMEs (CenterPoint, Durham, ECBH, and Five County) met or exceeded the target.

[22] *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health,* Table B.20, published February 2008 http://oas.samhsa.gov/nsduh.htm. Estimates applied to county population as of July 2008.

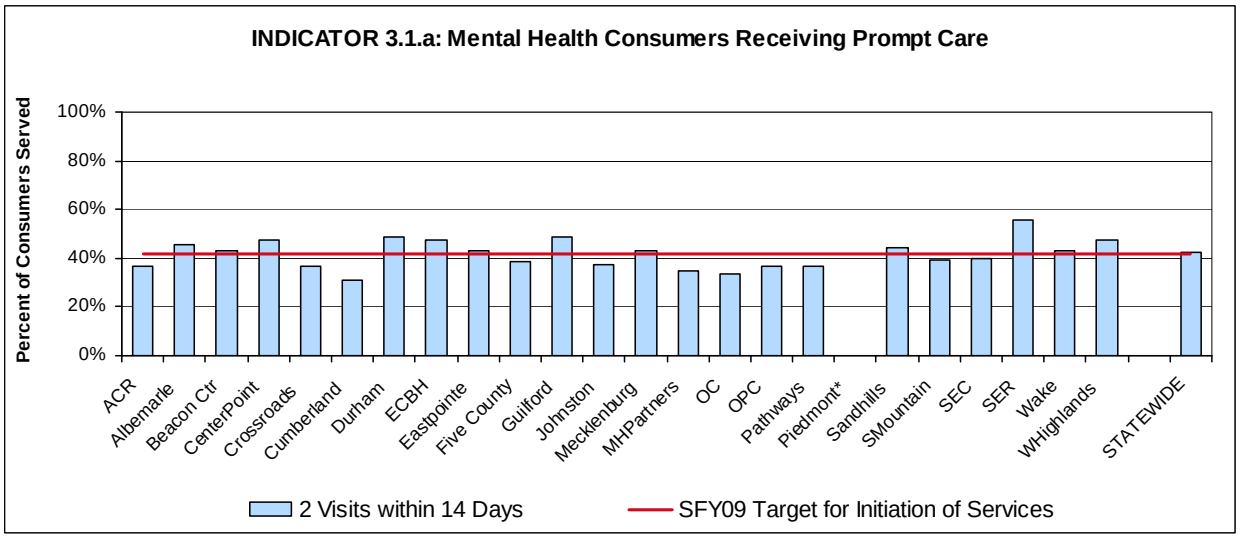
[23] The numbers served reflect adolescents, ages 12-17, who received any SA services (including assessments) in the community system, paid through Medicaid and/or IPRS. Persons not included are those served outside of the state Unit Cost Reimbursement (UCR) system, such as those receiving grant-funded SA services and some services to persons as an alternative to incarceration. The state UCR system also does not include persons whose services are paid by Medicare, Health Choice, county funds, other federal, state, and local agencies, and private sources. The data does not account for privately-insured consumers; therefore 100% of the population is not expected to be served by the public community system.

[24] The SFY 2009 DHHS-LME Performance Contract requirement is 7% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.a Initiation of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=40,647 consumers

Forty-two percent of NC residents (all age groups) who received mental health services had two visits in the first 14 days of care. Among LMEs, this percent ranged from a low of 31% (Cumberland) to a high of 56% (Southeastern Regional). Compared to the other disability groups, consumers with mental illness had the lowest percentage receiving two visits in the first 14 days of care.

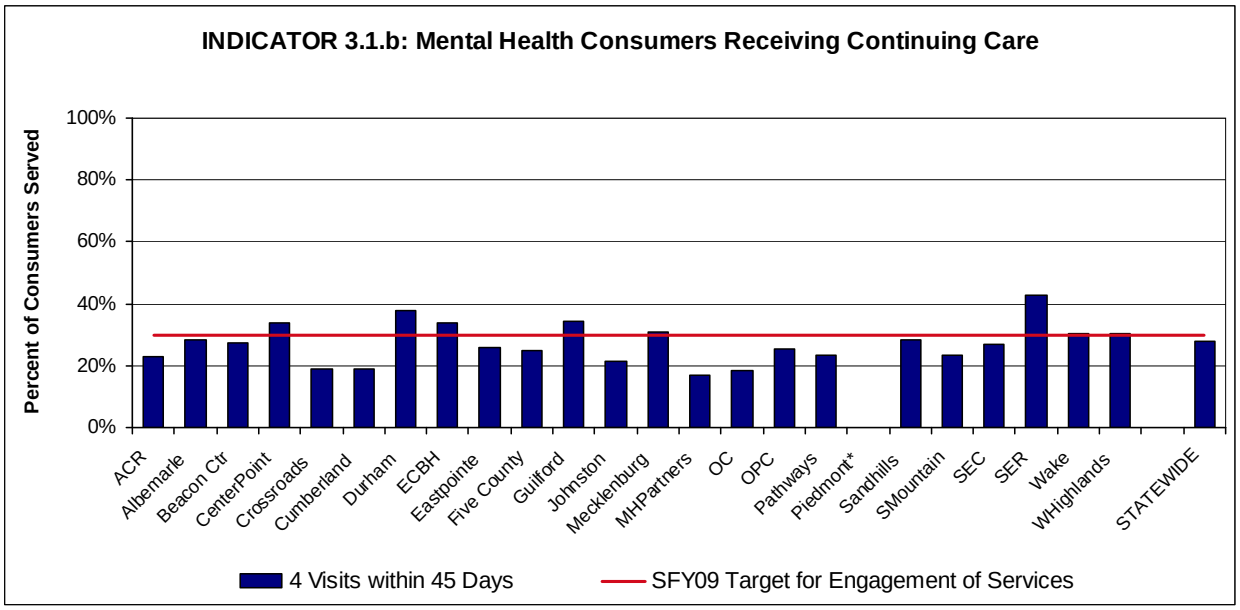
The established SFY 2009 target for initiation of mental health consumers into care is 42%, as indicated by the red line in the graph above[25]. Of the 23 LMEs with service claims data, more than half (12 LMEs) met or exceeded the target.

[25] The SFY 2009 DHHS-LME Performance Contract requirement is 37% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.1.b Engagement of Mental Health Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=40,647 consumers

More than one-fourth (28%) of mental health consumers met the initiation standard (two visits within 14 days of care) and had an additional two visits within the next 30 days, making a total of four visits in the first 45 days (a best practice for engagement in care). Among LMEs, engagement ranged from a low of 17% (Mental Health Partners) to a high of 43% (Southeastern Regional). Compared to the other disability groups, consumers with mental illness had the lowest percentage of persons receiving four visits in the first 45 days of care.

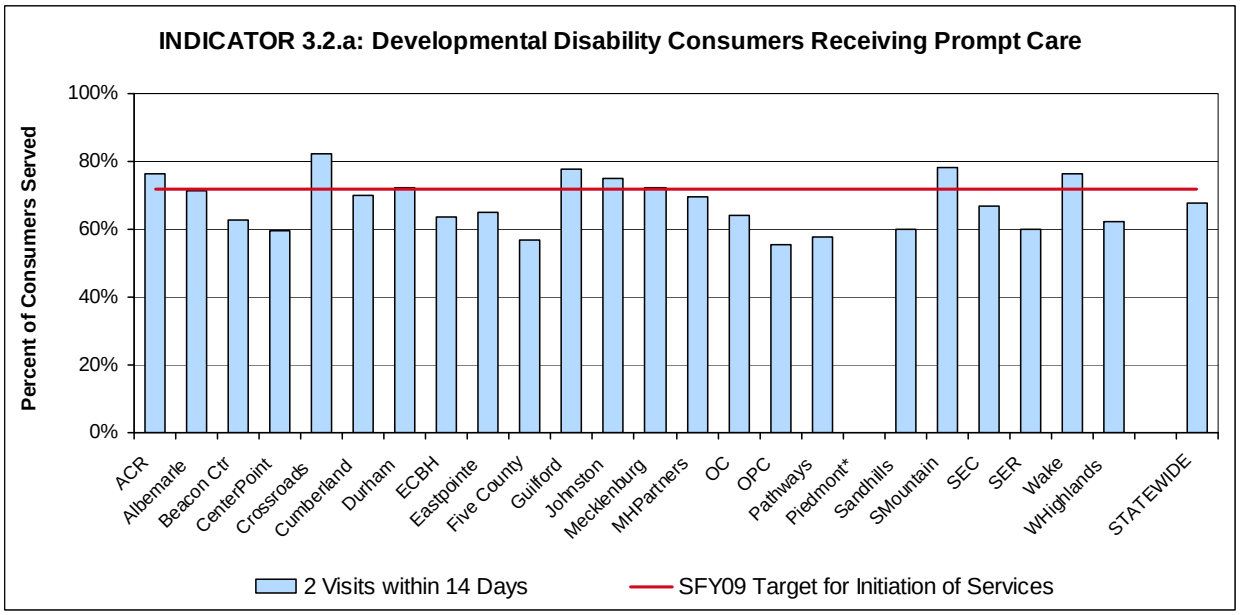
The established SFY 2009 target for engagement of mental health consumers into care is 30%, as indicated by the red line in the graph above[26]. Of the 23 LMEs with service claims data, more than one-third of the LMES (8 LMEs) met or exceeded the target.

[26] The SFY 2009 DHHS-LME Performance Contract requirement is 25% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.a Initiation of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=958 consumers

Sixty-eight percent of NC residents (all age groups) who received developmental disability services/supports had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranged from a low of 56% (OPC) to a high of 82% (Crossroads). Compared to the other disability groups, consumers with developmental disabilities had the highest percentage receiving two visits in the first 14 days of care.

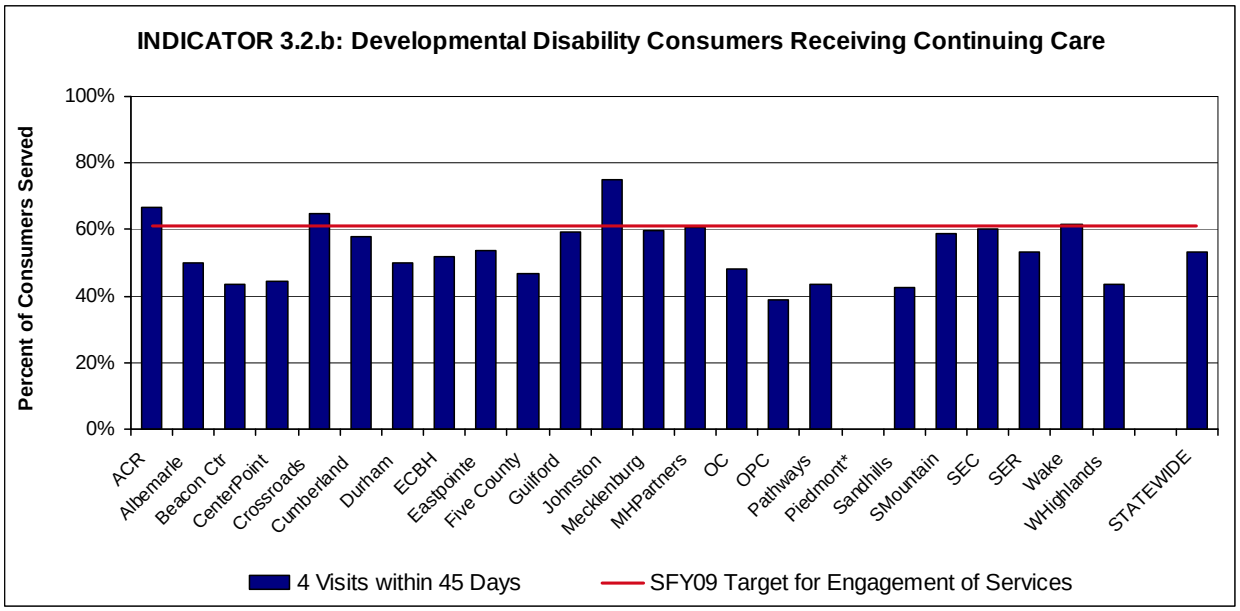
The established SFY 2009 target for initiation of developmental disability consumers into care is 72%, as indicated by the red line in the graph above[27]. Of the 23 LMEs with service claims data, more than one-third of the LMEs (8 LMEs) met or exceeded the target.

[27] The SFY 2009 DHHS-LME Performance Contract requirement is 62% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.2.b Engagement of Developmental Disability Consumers

Rationale: Best practice for initiating and engaging consumers in care suggests that an individual receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=958 consumers

Fifty-three percent of developmental disability consumers met the initiation standard (two visits within 14 days of care) and had an additional two visits within 30 days, making a total of four visits in the first 45 days (a best practice for engagement in care). Among LMEs, engagement ranged from a low of 39% (OPC) to a high of 75% (Johnston). Compared to the other disability groups, consumers with developmental disabilities had the highest percentage of persons receiving four visits in the first 45 days of care.

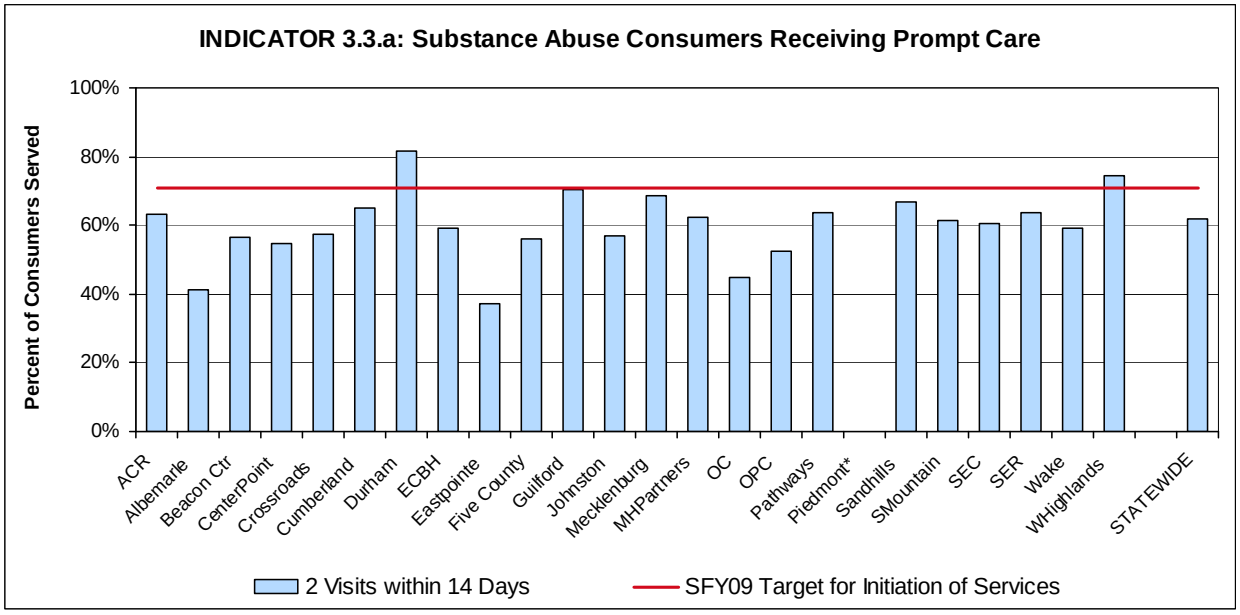
The established SFY 2009 target for engagement of developmental disability consumers into care is 61%, as indicated by the red line in the graph above[28]. Of the 23 LMEs with service claims data, one-fifth or 5 LMEs (Alamance-Caswell-Rockingham, Crossroads, Johnston, Mental Health Partners, and Wake) met or exceeded the target.

[28] The SFY 2009 DHHS-LME Performance Contract requirement is 51% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.a Initiation of Substance Abuse Consumers

Rationale: National standards[29] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=4,791 consumers

Sixty-two percent of NC residents (all age groups) who received substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranged from a low of 37% (Eastpointe) to a high of 81% (Durham).

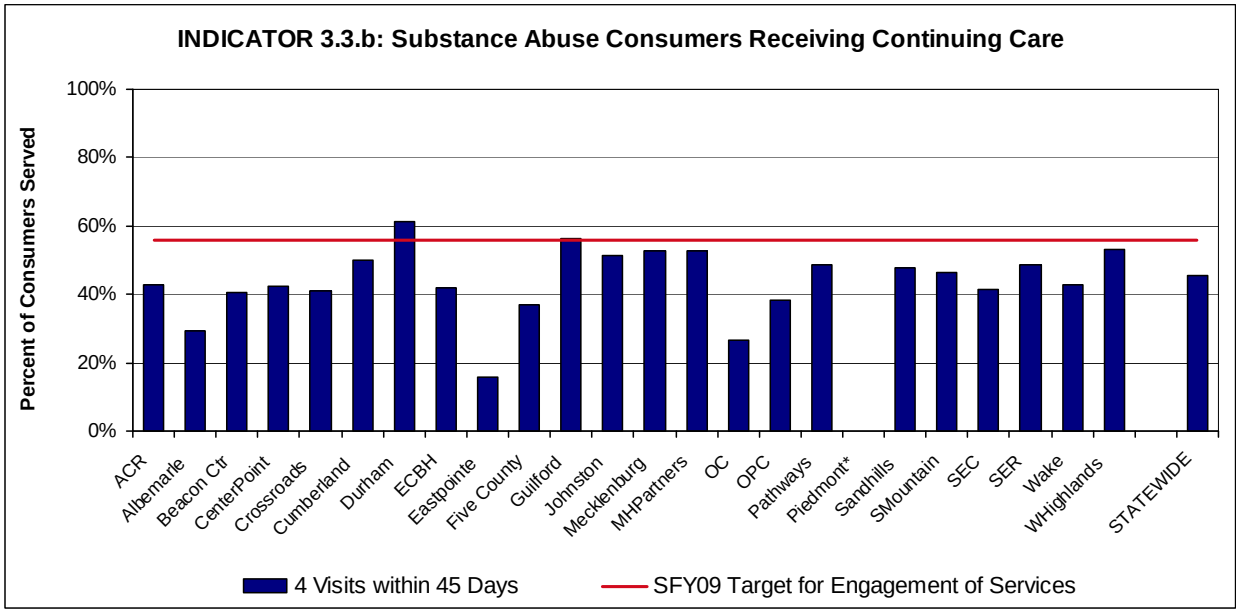
The established SFY 2009 target for initiation of substance abuse consumers into care is 71%, as indicated by the red line in the graph above[30]. Of the 23 LMEs with service claims data, 3 LMEs (Durham, Guilford, and Western Highlands) met or exceeded the target.

[29] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[30] The SFY 2009 DHHS-LME Performance Contract requirement is 64% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.3.b Engagement of Substance Abuse Consumers

Rationale: National standards[31] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=4,791 consumers

Less than half (46%) of substance abuse consumers met the initiation standard (two visits within 14 days of care) and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). Among LMEs, engagement ranged from a low of 16% (Eastpointe) to a high of 61% (Durham).

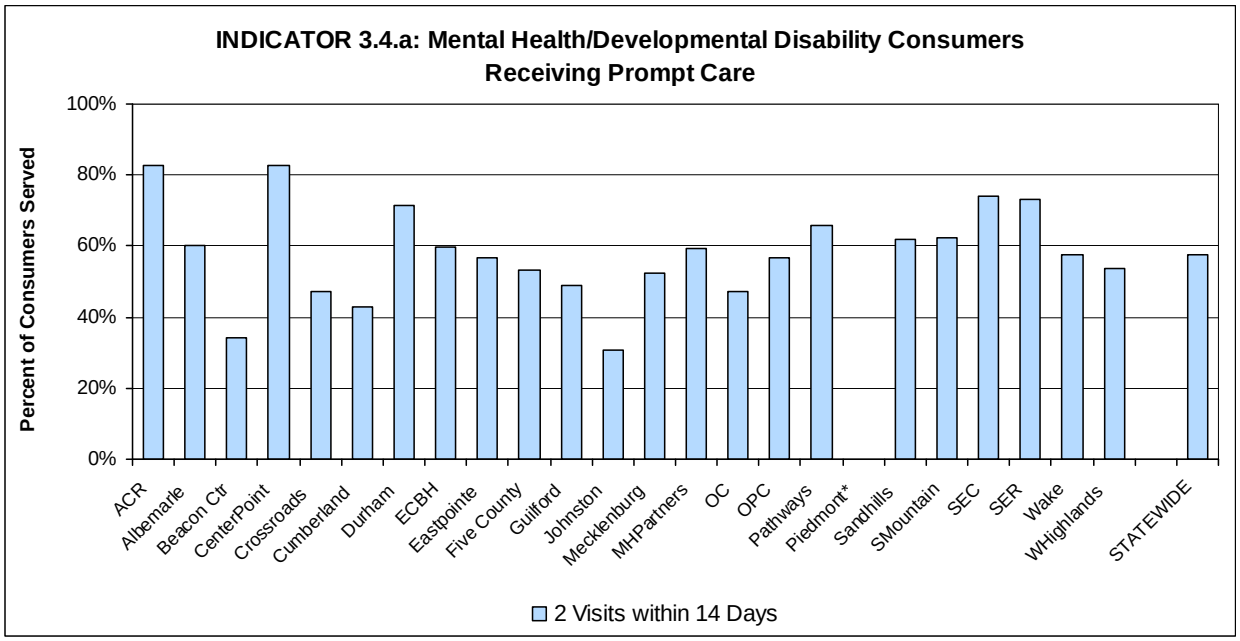
The established SFY 2009 target for engagement of substance abuse consumers into care is 56%, as indicated by the red line in the graph above[32]. Of the 23 LMEs with service claims data, two LMEs (Durham and Guilford) met or exceeded the target.

[31] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.
[32] The SFY 2009 DHHS-LME Performance Contract requirement is 47% or above.

Indicator 3: Timely Initiation and Engagement in Service

3.4.a Initiation of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=1,033 consumers

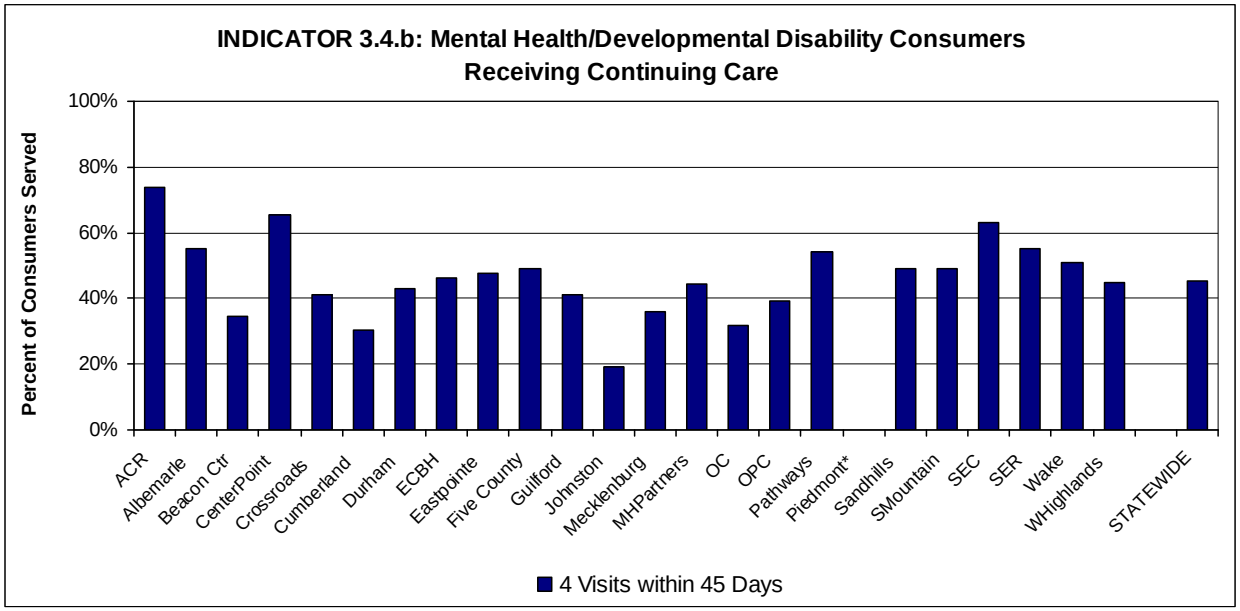
Fifty-eight percent of NC residents (all age groups) who received both mental health and developmental disability services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranged from a low of 31% (Johnston) to a high of 83% (Alamance-Caswell-Rockingham and CenterPoint).

A SFY 2009 target for initiation for consumers in need of co-occurring mental health and developmental disability services has not been established.

Indicator 3: Timely Initiation and Engagement in Service

3.4.b Engagement of Co-Occurring Mental Health/Developmental Disability Consumers

Rationale: National standards for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=1,033 consumers

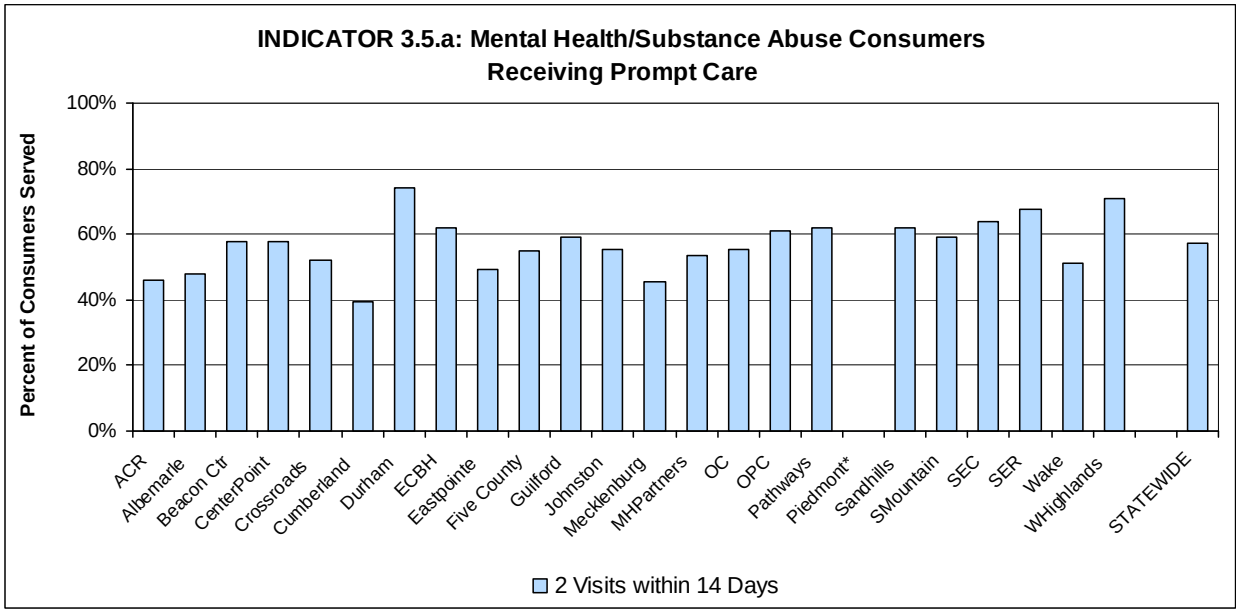
Forty-five percent of NC consumers who received both mental health and developmental disability services met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). Among LMEs, engagement ranged from a low of 19% (Johnston) to a high of 74% (Alamance-Caswell-Rockingham).

A SFY 2009 target for engagement for consumers in need of co-occurring mental health and developmental disability services has not been established.

Indicator 3: Timely Initiation and Engagement in Service

3.5.a Initiation of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[33] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=5,486 consumers

Almost three-fifths (57%) of NC residents (all age groups) who received both mental health and substance abuse services had two visits in the first 14 days of care (the standard for prompt initiation of care). Among LMEs, this percent ranged from a low of 40% (Cumberland) to a high of 74% (Durham).

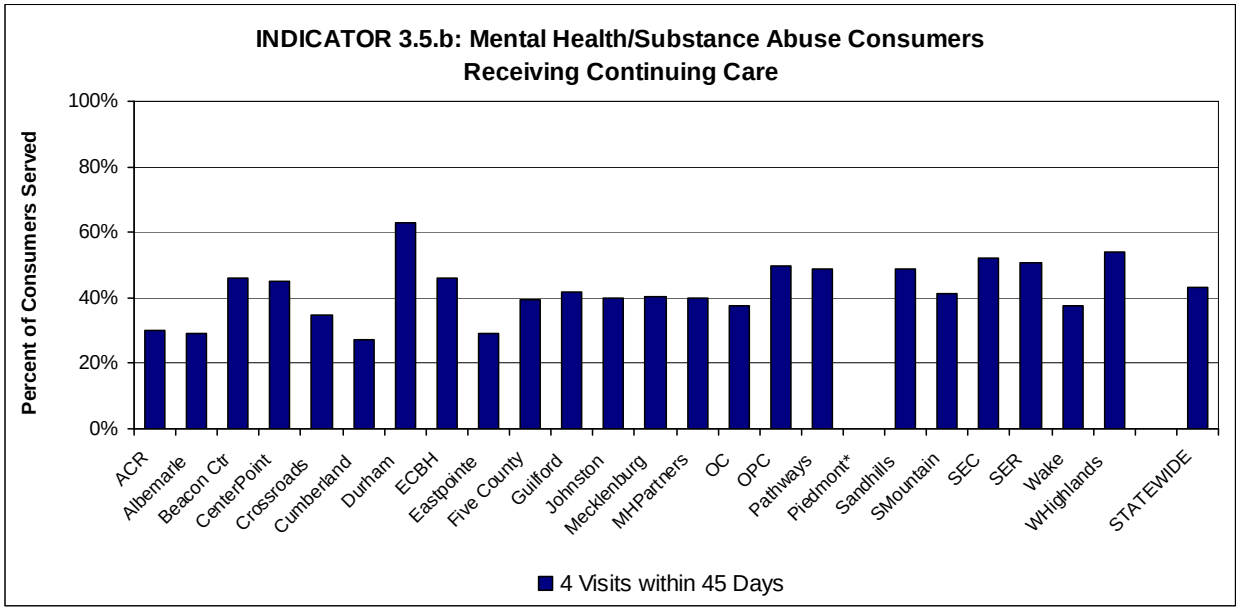
A SFY 2009 target for initiation for consumers in need of co-occurring mental health and substance abuse services has not been established.

[33] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 3: Timely Initiation and Engagement in Service

3.5.b Engagement of Co-Occurring Mental Health/Substance Abuse Consumers

Rationale: National standards[34] for initiating and engaging consumers in care require an individual to receive two visits within the first 14 days of care and an additional 2 visits within the next 30 days (a total of 4 visits within the first 45 days of service). These timelines provide the best opportunity for an individual to become fully engaged in services that can promote recovery and stability.



SOURCE: Medicaid and State Service Claims Data. January 1 - March 31, 2008 (first service received); N=5,486 consumers

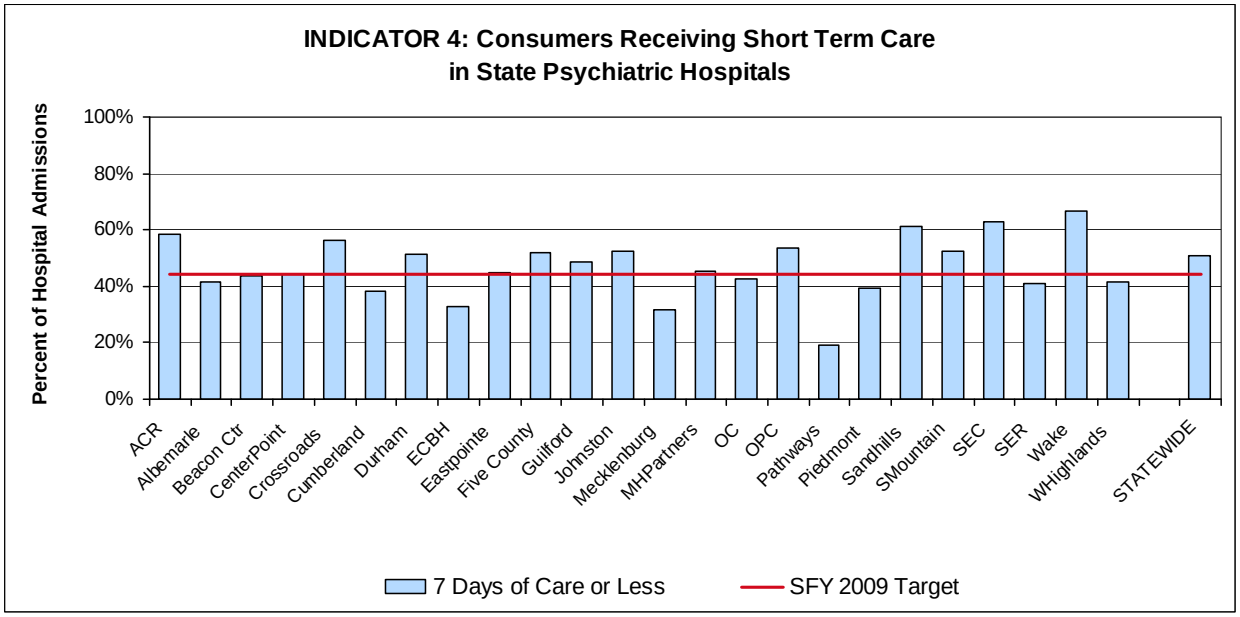
Forty-three percent of NC consumers who received both mental health and substance abuse services met the initiation standard of two visits within 14 days and had an additional two visits within 30 days, making a total of four visits in the first 45 days (the standard for engagement in care). Among LMEs, engagement ranged from a low of 27% (Cumberland) to a high of 63% (Durham).

A SFY 2009 target for engagement for consumers in need of co-occurring mental health and substance abuse services has not yet been established.

[34] Washington Circle Public Sector Workgroup, www.washingtoncircle.org.

Indicator 4: Effective Use of State Psychiatric Hospitals

Rationale: State psychiatric hospitals provide a safety net for the community service system. An adequate community system can and should provide their residents with crisis services and short-term inpatient care close to home. This helps families stay in touch and reserves high-cost state facility beds for consumers with long-term care needs. *Reducing* the short-term use of state psychiatric hospitals is a goal that also allows more effective and efficient use of funds for community services.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during July 1 - September 30, 2008; N=2,459 discharges

Of the statewide hospital discharges from July through September 2008, slightly more than half (51%) of the persons discharged were hospitalized for 7 days or less. (Note: As seen in the *Appendix*, one-third, 33%, were hospitalized for 8-30 days). Lengths of stay for 1-7 days varied by LME from a high of 67% (Wake) to a low of 19% (Pathways).

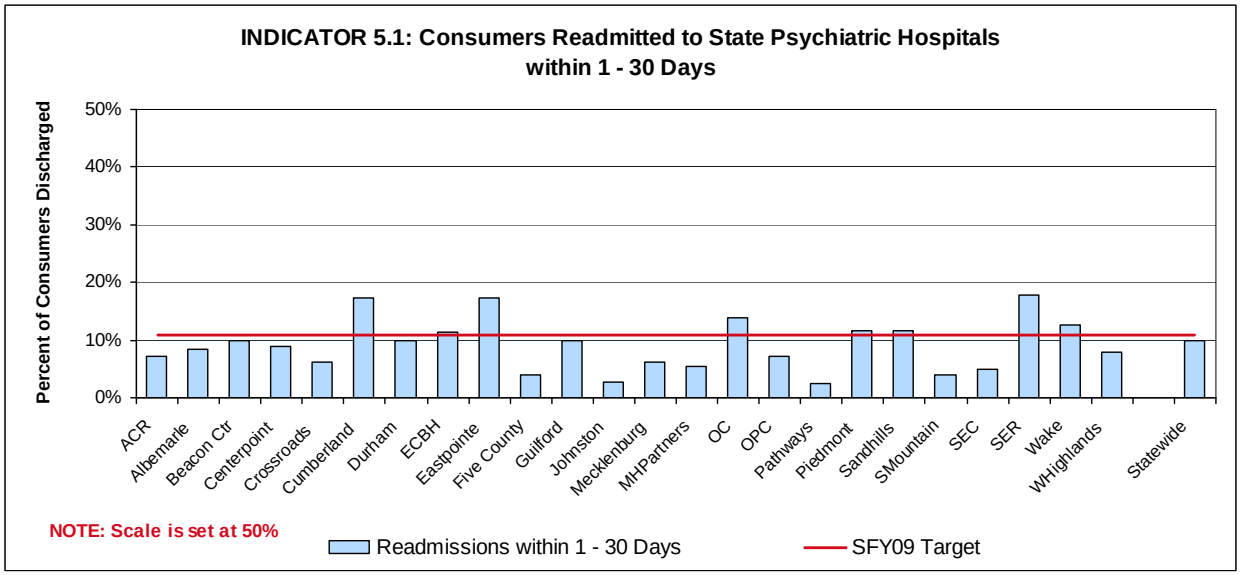
The established SFY 2009 target for short-term (7 days or less) use of state psychiatric hospitals is no more than 44%, as indicated by the red line in the graph above[35]. Of the 24 LMEs with HEARTS data, almost half (11 LMEs) met or exceeded the target.

[35] The SFY 2009 DHHS-LME Performance Contract requirement is 55% or below.

Indicator 5: State Psychiatric Hospital Readmissions

5.1 State Psychiatric Hospital Readmissions within 1-30 Days

Rationale: Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during January 1 - March 31, 2008); N=2,874 discharges

Ten percent of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 30 days. Among LMEs, the percent of consumers readmitted within 30 days varied from a high of 18% (Southeastern Regional) to a low of 3% (Johnston and Pathways).

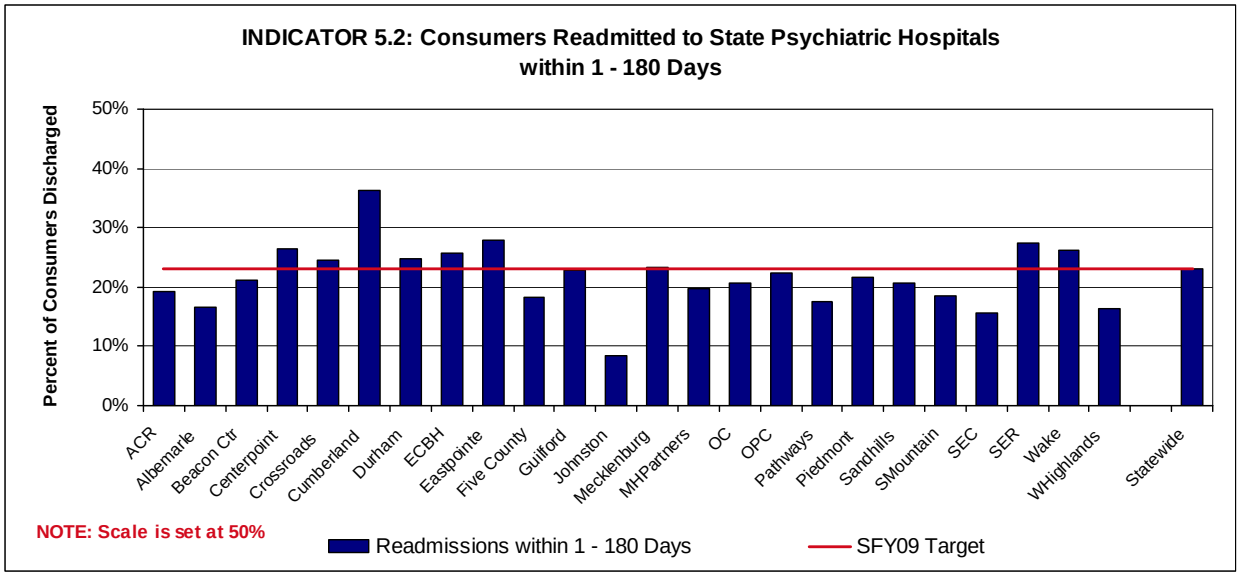
The established SFY 2009 target for readmissions within 30 days of discharge from a state psychiatric hospital is no more than 11%, as indicated by the red line in the graph above[36]. Almost three-quarters of the LMEs (17 LMEs) met or exceeded the target.

[36] The SFY 2009 DHHS-LME Performance Contract requirement is 12% or below.

Indicator 5: State Psychiatric Hospital Readmissions

5.2 State Psychiatric Hospital Readmissions within 1-180 Days

Rationale: Successful community living, without repeated admissions to inpatient psychiatric care, requires effective coordination and ongoing appropriate levels of community care after hospitalization. A low psychiatric hospital readmission rate is a nationally accepted standard of care that indicates how well a community is assisting individuals at risk for repeated hospitalizations.



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for hospital discharges during January 1 - March 31, 2008); N=2,874 discharges

Less than one-fourth (23%) of consumers discharged from state psychiatric hospitals were readmitted to a psychiatric hospital within 180 days. Among LMEs, the percent of consumers readmitted within 180 days varied from a high of 36% (Cumberland) to a low of 8% (Johnston).

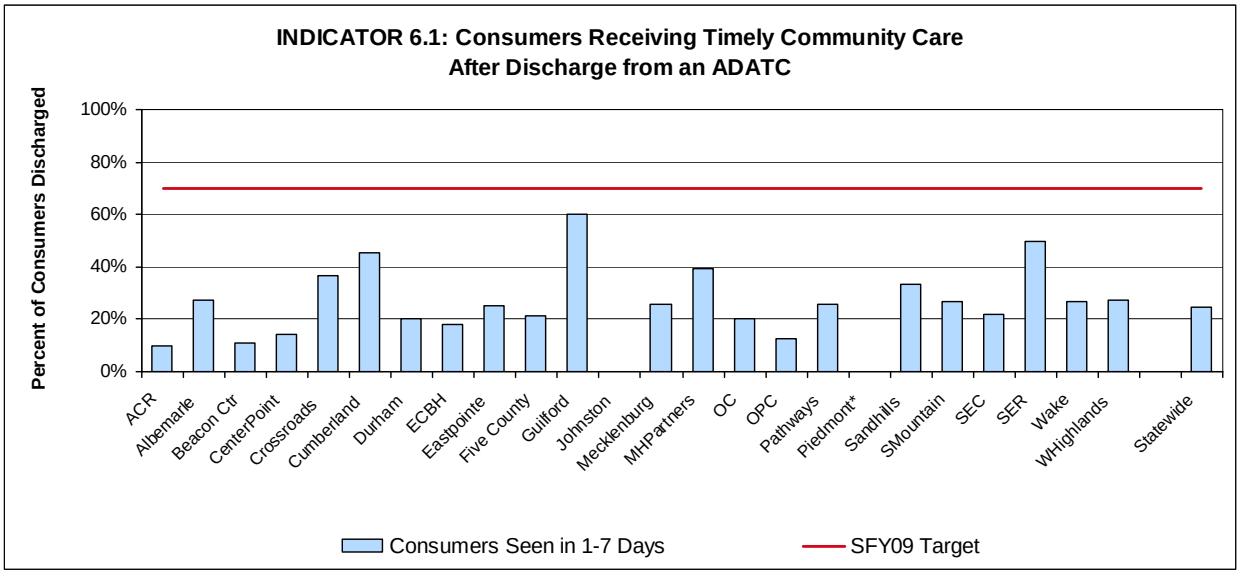
The established SFY 2009 target for readmissions within 180 days of discharge from a state psychiatric hospital is no more than 23%, as indicated by the red line in the graph above[37]. Two-thirds of LMEs (16 LMEs) met or exceeded the target.

[37] The SFY 2009 DHHS-LME Performance Contract requirement is 26% or below.

Indicator 6: Timely Follow-Up after Inpatient Care

6.1 ADATCs

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[38]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for ADATC discharges April 1 - June 30, 2008; Medicaid and State Service Claims Data for claims paid through October 31, 2008; N=847 discharges

Statewide, one-fourth (25%) of consumers discharged from an ADATC received follow-up care in the community within 7 days. An additional 12% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*).

Among LMEs, the percentage of consumers receiving follow-up care within 7 days varied from a low of 0% (Johnston) to a high of 60% (Guilford).

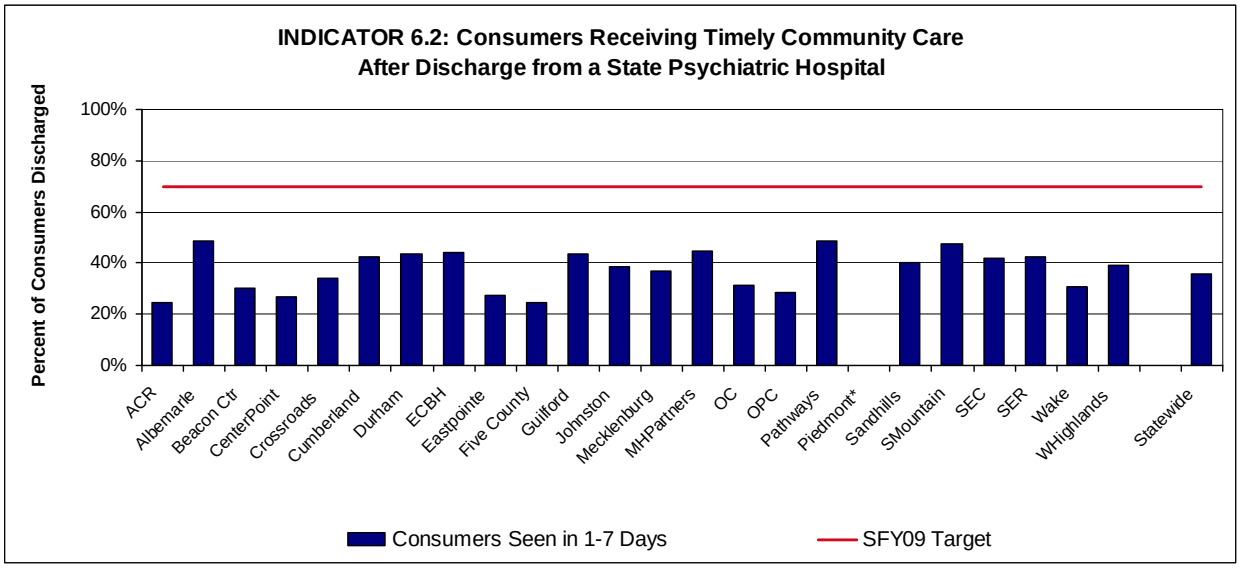
The established SFY 2009 target for follow-up care in the community within 7 days of discharge from an ADATC is 70%, as indicated by the red line in the graph above[39]. Of the 23 LMEs with service claims data, no LMEs met or exceeded the target.

[38] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[39] The SFY 2009 DHHS-LME Performance Contract requirement is 26% or above.

Indicator 6: Timely Follow-Up after Inpatient Care

6.2 State Psychiatric Hospitals

Rationale: Living successfully in one's community after discharge from a state-operated facility depends on smooth and timely transition to community services/ supports. Receiving a community-based service within 7 days of discharge is a nationally accepted standard of care that also indicates the local system's community service capacity and coordination across levels of care.[40]



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) data for Hospital discharges April 1 - June 30, 2008); Medicaid and State Service Claims data for claims paid through October 31, 2008); N=2,639 discharges

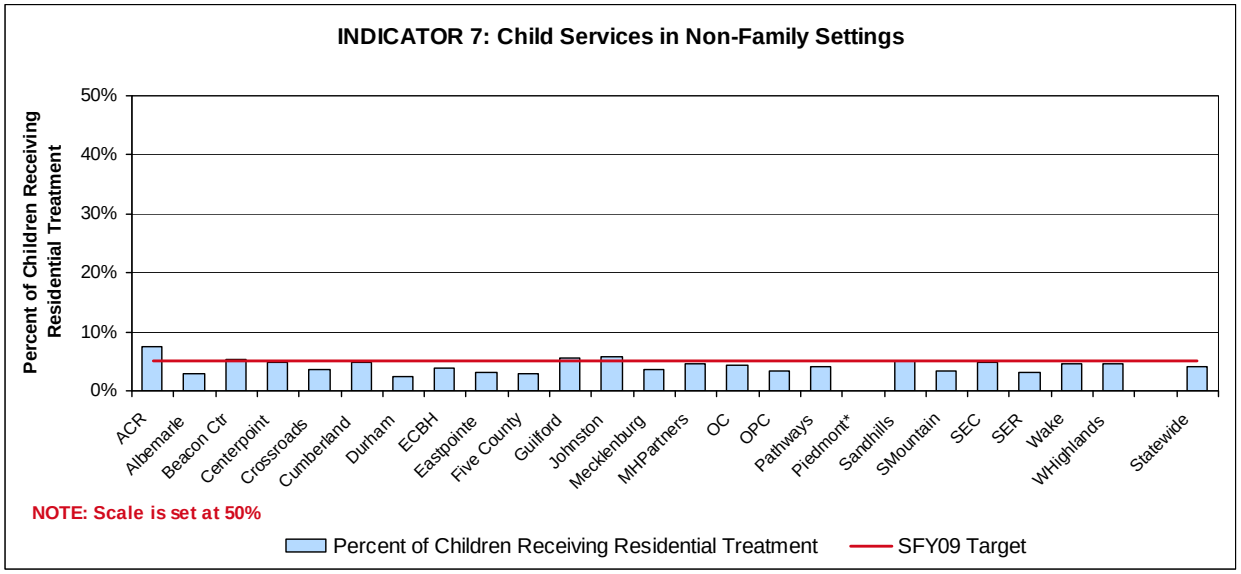
Statewide, over one-third (36%) of consumers discharged from state psychiatric hospitals received follow-up care in the community within 7 days. An additional 14% of NC consumers were seen within 8-30 days of discharge (not shown in the graph above; see *Appendix*). Among LMEs, the percent of consumers receiving follow-up care within 7 days varied from a low of 24% (Alamance-Caswell-Rockingham and Five County) to a high of 49% (Pathways).

The established SFY 2009 target for follow-up care in the community within 7 days of discharge from a state psychiatric hospital is 70%, as indicated by the red line in the graph above[41]. Of the 23 LMEs with service claims data, no LMEs met or exceeded the target.

[40] This is a Health Plan Employer Data and Information Set (HEDIS®) measure.
[41] The SFY 2009 DHHS-LME Performance Contract requirement is 35% or above.

Indicator 7: Child Services in Non-Family Settings

Rationale: Children and adolescents served in the most natural and least restrictive community settings appropriate to their needs are more likely to maintain or develop positive family and community connections and to achieve other lasting, positive outcomes.



SOURCE: Medicaid and State Service Claims Data for services received April 1 - June 30, 2008 paid through October 31, 2008; N=62,087 child and adolescent consumers served with a MH or SA diagnosis (includes those with co-occurring DD)

Statewide, 2,559 (4%) children and adolescents receiving mental health and/or substance abuse services were served in residential treatment settings[42]. Among LMEs, the percentage of child and adolescent consumers served in residential settings ranged from a high of 7% (Alamance-Caswell-Rockingham) to a low of 2% (Durham).

The established SFY 2009 target for child services in non-family settings is no more than 5%, as indicated by the red line in the graph above[43]. Of the 23 LMEs with service claims data, all but three of the LMEs met or exceeded the target.

[42] Includes Level 2 (Program Type), Level 3, and Level 4 Residential Treatment Services.
[43] The SFY 2009 DHHS-LME Performance Contract requirement is 6% or below.

The MH/DD/SAS *Community Systems Progress Report*, *Report Appendices* and *Critical Measures at a Glance* are published four times a year on the Division's website:
http://www.ncdhhs.gov/mhddsas/statspublications/reports/

Questions and feedback should be directed to:
NC DMH/DD/SAS Quality Management Team
ContactDMHQuality@ncmail.net
(919/733-0696)